Emergency Card Information

Child's Name: ____ DOB_____/_____/__________ Grade: _____
Last First Middle MM DD YYYY

Child's Home Address ____ ______ - ______ - __________
Street City Zip Home Phone

INSTRUCTIONS TO REACH PARENT/GUARDIAN

Name ____ ______ - ______ - __________
Last First Phone

Name ____ ______ - ______ - __________
Last First Phone

PEDIATRICIAN OR SOURCE OF HEALTH CARE

Doctor's Name ____
Last First

Address ____ ______ - ______ - __________
Street City Zip Phone

LOCAL EMERGENCY CONTACT PERSON(S)

Name ____ ______ - ______ - __________
Last First Phone

Name ____ ______ - ______ - __________
Last First Phone

MEDICAL INFORMATION
List any allergies, chronic health conditions, medications, or write "NONE."

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INSURANCE INFORMATION (OPTIONAL)

______________________ ______________________ ______________________
Company Name Policy # Participating Hospital

____
Special Instructions

MEDICATION AUTHORIZATION AND CONSENT

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I/we cannot be reached, I hereby authorize Angier After School Program to transport my child to the Hospital (by ambulance if the situation warrants) and to secure for my child the necessary medical treatment. I understand the teachers at AASP are trained in the basics of First Aid and CPR and I authorize them to give my child first aid and/or CPR when appropriate.

Name:______________________________________ Date: _____/_____/__________
Parent/Guardian Signature MM DD YYYY